Common incontinence problems seen by community nurses

Olufunmilola Kehinde

Incontinence is associated with other medical conditions and has a variety of social and physiological consequences — from the person who has had a stroke and who needs to urgently empty their bladder; to someone with dementia who has lost the ‘skills’ of continence.

Community nurses who are able to manage people’s continence needs can help to restore patient’s dignity and improve quality of life, as well as preventing wastage and saving limited NHS resources (All Party Parliamentary Group for Continence Care [APPG], 2011). Knowing what constitutes ‘good’ continence services will also help patients and carers understand the services on offer, as well as making it easier for nurses to deliver standard outcomes. This article looks at recent guidelines that outline measurable continence services for adults, children and young people (APPG, 2011).

KEYWORDS:
Continence ■ Urinary and faecal incontinence ■ Vulnerable adults

Incontinence is a common problem that affects people of all ages, and all social and cultural backgrounds, and while it is not a life-threatening condition it is associated with decreasing quality of life (Chiaffarino et al, 2003).

Hisser (1999) indicated that patients with incontinence are also at risk of skin breakdown, recurrent urinary tract infections, and falls, especially when they have symptoms of urgency and urge incontinence (see Table 1) or nocturia, and that these are linked to complications that can lead to hospital admission (e.g. pressure ulcers, urinary tract infection, catheterisation and faecal impaction).

The psychological consequences of incontinence can cause embarrassment and prevent people from travelling far from home, while feelings of isolation can affect personal and sexual relationships and body image. In some cases, incontinence can lead to feelings of depression and/or social problems such as not being able to work.

Incontinence is one of the so called ‘geriatric giants’, or issues that affect people as they grow older, as well as being a main cause of admission to long-term care facilities. Studies by du Moulin et al (2005; 2010) showed that incontinence increases admission into care homes, in particular, while the Registered Nurses’ Association of Ontario (RNAO, 2005) stated that:

Family care providers of incontinent individuals report continence maintenance as burdensome and urinary incontinence plays an important role in the decision to institutionalise elderly family members.

Unfortunately, urinary incontinence is often seen as a ‘minor problem’ or viewed as a normal part of the ageing process for which no treatment is needed (Dugan et al, 2001). In many cases, patients have no real understanding of treatment options, and instead of seeking professional help seek out incontinence products in shops or from the internet.

PREVALENCE

Estimates of the prevalence of incontinence differ widely due to the use of diverse study populations, varying definitions of incontinence, and different methods of study. Incontinence involves the loss of control of bowel movements and/or urination, but can vary in severity. Incontinence occurs for a variety of different reasons, and it is important to differentiate between faecal and urinary incontinence. Overall, evidence suggests that bladder problems affect more than 14 million people in the UK, whereas approximately 6.5 million have bowel issues (Oxtoby, 2016).

URINARY INCONTINENCE

Abrams et al (2002), in collaboration with the International Continence Society (ICS), defined urinary incontinence as an involuntary leakage of urine, while a study of people living in the community reported a prevalence of 21%, with a higher prevalence in women and those over 65 years of age (Perry et al, 2000). The study also demonstrated that approximately 23% of women and 8.7% of men over 40 years of age had some kind of urinary symptoms and that the prevalence and severity of these increases with age (Perry et al, 2000).

For people with cognitive impairment or dementia who live at home, results from a recent systematic review reported that the prevalence of urinary incontinence ranges from 1.1% in the general community population to 38% of those receiving home care services (Orrell et al, 2013).

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involuntary loss of flatus or stool. It can be caused by an injury during labour or as a result of surgery to the small pelvis or pelvic floor, causing damage to sphincter innervation of the urinary bladder and rectum, as well as direct damage to the sphincter itself (Sievert et al, 2012).

The estimated prevalence of faecal incontinence is 1–15% (Macmillan et al, 2004; National Institute for Health and Care Excellence [NICE], 2007); however, in nursing homes this figure can be much higher at 10–50%. Indeed, patients or their carers no longer being able to cope with faecal incontinence is often the reason why people are admitted to care homes in the first place.

The various presentations of faecal and urinary incontinence are shown in Table 1.

**VULNERABLE ADULTS**

Age-related changes to the urinary system makes it more difficult for people to retain continence as they grow older (Nazarko, 2012; Nguyen and Goldfarb, 2012; Wehrberger et al, 2012). Adults depend on a complex system of hormonal, muscular, and neurological controls to remain continent, however, these controls can become damaged or weaken with age. Similarly, long-term conditions such as stroke and dementia (Shamliyan et al, 2007), and/or treatment for conditions like heart failure can also lead to urinary incontinence. For example, patients who are taking diuretics for heart failure may also experienced increased frequency of micturition during the day (Tannenbaum and Johnell, 2014).

In the author’s experience, many older people do not access support with urinary incontinence due to embarrassment and even if they do look for advice, they are often told that their problems are due to ageing. Similarly, many older people themselves are under the impression that incontinence ‘cannot be helped’ and rarely consult GPs or community nurses, even during appointments for other conditions.

Older people living in the community face enormous challenges when trying to manage their own continence issues and a significant number use less than ideal homemade methods, such as trying to construct makeshift pads from toilet roll, cloths and sanitary towels. As a consequence, many older people restrict their social outings, for example, or are afraid to go shopping unless they know where toilets are located and how fast they can access them. As the problem progresses, they may even avoid visits from friends or family to lessen the embarrassment of potential ‘accidents’.

The decreased physical activity that accompanies increasing age inevitably contributes to mobility problems, falls, declining mood, limited social interactions, loss of confidence and social isolation (age-related causes of incontinence are listed in Table 2).

**Incontinence and dementia**

Many community nurses may come across patients with dementia and

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**Table 1: Types of urinary and faecal incontinence (NICE, 2007; 2015)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary incontinence</td>
<td>Stress incontinence involves the involuntary leakage of urine linked with exertion (such as sneezing or coughing), which raises the intra-abdominal pressure and puts stress on the pelvic floor, leading to leakage of small volumes of urine</td>
</tr>
<tr>
<td></td>
<td>Urgency urinary incontinence is the involuntary leakage of urine, alongside or instantly preceding a sudden urgent desire to void that cannot be delayed. Urgency urinary incontinence can result in larger volumes of leakage</td>
</tr>
<tr>
<td></td>
<td>Mixed urinary incontinence involves the involuntary leakage of urine accompanying the unexpected urge to void and exertion. The individual experiences both small and significant amounts of leakage</td>
</tr>
<tr>
<td></td>
<td>Overflow incontinence is the involuntary leakage associated with poor bladder emptying, which can be the result of neurological impairment, pelvic surgery, constipation, pregnancy, prolapse, medication and an enlarged prostate</td>
</tr>
<tr>
<td></td>
<td>Nocturnal enuresis is the involuntary leakage of urine at night, which can be linked with an overactive bladder, medication and sleep apnoea</td>
</tr>
<tr>
<td></td>
<td>Functional incontinence has no organic source but is connected with cognitive or physical impairment; that is the person’s ability to reach or use the toilet effectively</td>
</tr>
<tr>
<td>Faecal incontinence</td>
<td>Overflow incontinence is secondary to constipation and stool impaction</td>
</tr>
<tr>
<td></td>
<td>Dementia-related incontinence is caused by the loss of voluntary control over the external sphincter in combination with decreasing awareness of the need for continence</td>
</tr>
<tr>
<td></td>
<td>Functional incontinence occurs in individuals who are incapable of accessing the toilet in time, which might be due to impairment in mobility, dexterity, communication or vision</td>
</tr>
<tr>
<td></td>
<td>External anal sphincter weakness (possibly related to previous obstetric trauma, age-related changes or as a complication of rectal surgery)</td>
</tr>
<tr>
<td></td>
<td>Excessive use of laxatives</td>
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continence issues, particularly in care homes. However, incontinence rarely symbolises a failure in the physical control of the bladder and bowel in early dementia. Rather, the irrevocable decline of intellectual ability, including memory loss, reduced language skills and impaired thinking result in behavioural difficulties with using the toilet. A number of cognitive skills and physical actions are required for successful toileting and any deficit in these can result in incontinence.

This complex chain of physical and cognitive skills required for continence can break down at any point due to disease, disability, emotional disorder, environmental factors (e.g. where a patient may be moved into an unfamiliar environment with low toilet seats), comorbidities, or a mixture of all these issues (Stokes, 2002).

The severity of cognitive impairment and reduced mobility are important related factors in the development of incontinence in people with dementia (Bardsley, 2013), while research suggests that the presence of nocturia (the need to get up in the night to urinate) is an additional risk for urinary incontinence (Mui et al, 2010).

Incontinence is not an inevitable consequence of dementia, but it is common and community nurses need to have strategies in place to support people affected, not only in hospitals, care homes and day care facilities, but also for those living at home alone or with a carer (Andrew, 2013).

Protecting people’s dignity is important in the management of continence, but this can be challenging when working with people with dementia. Caring in this patient group can be complicated by patients not being able to react quickly enough to the sensation of needing to use the toilet or failing to get to the toilet in time, sometimes due to mobility problems caused by other conditions such as arthritis. People with dementia may also find it difficult to communicate the need to go to the toilet or be unable to find, recognise, or use the toilet. Similarly, if someone becomes confused about their surroundings, they may urinate in an inappropriate place (such as a wastepaper basket) because they have mistaken it for a toilet. Providing regular reminders about using the toilet is a common approach, as is regular ‘toileting’ by carers and providing toileting aids such as handheld urinals and commodes.

Since dementia mainly affects older people, many are also affected by the sensory or physical impairments of ageing, such as reduced mobility or poor eyesight. Depending on the type of dementia, the patient may also have difficulty with ‘higher’ levels of cognition, making them more likely to fall or to fail to complete tasks such as going to the toilet. As well as the problems associated with cognitive decline, just like other adults, people with dementia are subject to other causes of incontinence (Bardsley, 2013), such as urinary tract infection, enlarged prostate (in men), constipation, side-effects of medication and/or irritable bowel syndrome.

**Red Flag**

**Isolation**

Community nurses should monitor patients who have suddenly stopped socialising or wanting to go to the shops, for example, as ceasing to take part in everyday activities can be a sign that they are worried about continence and embarrassing themselves in public.

**Table 2: Age-related contributing factors in incontinence**

<table>
<thead>
<tr>
<th>Urinary incontinence</th>
<th>Faecal incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in the amount of urine the bladder can hold and the ability of the urethra to open and close at the appropriate times</td>
<td>Diabetic neuropathy</td>
</tr>
<tr>
<td>Vaginal dryness and irritation caused by the decrease of oestrogen in women can cause a feeling of the need to urinate more frequently and may contribute to incontinence</td>
<td>Faecal impaction</td>
</tr>
<tr>
<td>An increase in post void residuals and involuntary bladder contractions</td>
<td>Rectocele or rectal prolapse</td>
</tr>
<tr>
<td>Men may experience difficulty emptying the bladder, because of prostate problems</td>
<td>Idiopathic degeneration</td>
</tr>
<tr>
<td>Decrease in mobility that makes it difficult to get to the bathroom in time following an urge to urinate</td>
<td>Constipation with overflow</td>
</tr>
<tr>
<td>Visual impairment that decreases the ability to distinguish and quickly find the bathroom</td>
<td>Neurological conditions such as Parkinson’s disease, stroke, and multiple sclerosis</td>
</tr>
<tr>
<td>Decreased hand strength and coordination may affect the ability to remove clothing for easier toileting</td>
<td></td>
</tr>
<tr>
<td>Sleep impairment resulting in frequent awakenings during the night</td>
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</tr>
</tbody>
</table>

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CONTINENCE

‘tipping point’ for carers and families due to the sheer hard work involved in dealing with wet or soiled clothes and the varying levels of dependency involved (Lobchuk and Rosenberg, 2014). There are numerous situations where personal functions usually taken for granted, such as continence, can ‘let people down’, taking away dignity and in some cases challenging the person’s ability to cope at home.

Bladder and bowel management in the UK is delivered by any number of healthcare professionals including GPs and staff in nursing and care homes, and community nurses have an important role (Perry et al, 2000). Nurses often have the appropriate interpersonal and technical skills to take an informal approach to continence that can help patients to relax.

The Department of Health (DH, 2000) indicated that all patients presenting with incontinence should be offered an initial assessment by a suitably trained individual. This assessment is in addition to the usual general patient assessment that looks at mental health, mobility and underlying conditions and might require a further consultation. Tables 3 and 4 indicate the factors required for an holistic continence assessment as well as the next steps that are required to provide ongoing evidence-based care.

Table 3: Main elements of continence assessment (DH, 2000)

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking symptoms and the effect they have on quality of life</td>
<td>Assess patient’s desire for treatment alternatives</td>
</tr>
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<td>Examine abdomen: palpable for mass or bladder retention</td>
</tr>
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<td>Examine the perineum to identify prolapse, excoriation and assess pelvic floor contraction</td>
</tr>
<tr>
<td>Examine rectum to exclude faecal impaction</td>
<td>Urinalysis to exclude infection</td>
</tr>
<tr>
<td>Urinalysis to exclude infection</td>
<td>Assess manual dexterity</td>
</tr>
<tr>
<td>Assess environment, e.g. access to toilet facilities</td>
<td>Use an ‘activities of daily living’ diary</td>
</tr>
<tr>
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<td>Identify conditions that may aggravate incontinence, e.g. chronic cough</td>
</tr>
</tbody>
</table>

Table 4: Initial primary care treatment for various types of continence

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer advice to patients and their carers about healthy living, in relation to diet and appropriate fluid intake</td>
<td>Put bladder and bowel training regimens into practice</td>
</tr>
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<td>Discuss/teach bladder training/timed voiding/prompted voiding for urge incontinence</td>
</tr>
<tr>
<td>Discuss/teach bladder training/timed voiding/prompted voiding for urge incontinence</td>
<td>Improve quality of life by providing easier access to toilet facilities and improving mobility, particularly in residential care, continuing care settings, schools and public places</td>
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<tr>
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<td>Discuss and teach pelvic floor exercises — particularly for women during and after pregnancy — to avoid or cure urinary stress incontinence; for patients with urge incontinence; and for men with post prostatectomy problems</td>
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<td>The quality of life for people with dementia and their carers can be improved by the use of incontinence aids such as pads</td>
</tr>
<tr>
<td>The quality of life for people with dementia and their carers can be improved by the use of incontinence aids such as pads</td>
<td>Discuss and teach pelvic floor and anal sphincter exercises, to improve faecal continence</td>
</tr>
<tr>
<td>Discuss and teach pelvic floor and anal sphincter exercises, to improve faecal continence</td>
<td>Provide continence aids such as enuresis alarms, sheath, urinals and pads</td>
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<tr>
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<td>Review medication as some drugs may precipitate or aggravate incontinence e.g. diuretics, analgesics</td>
</tr>
<tr>
<td>Review medication as some drugs may precipitate or aggravate incontinence e.g. diuretics, analgesics</td>
<td>Manage faecal impaction and treat constipation</td>
</tr>
<tr>
<td>Manage faecal impaction and treat constipation</td>
<td>Consider medication such as anticholinergic drugs, which may reduce overactive bladder and detrusor instability; and antidiuretic hormones for nocturnal enuresis, which temporarily reduce urine production</td>
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<tr>
<td>Consider medication such as anticholinergic drugs, which may reduce overactive bladder and detrusor instability; and antidiuretic hormones for nocturnal enuresis, which temporarily reduce urine production</td>
<td>Manage primary conditions such as urinary tract infection, constipation or atrophic vaginitis (inflammation of the vagina and surrounding tissue after menopause). These often respond to treatment and incontinence may possibly settle</td>
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<td>If patients are no longer able to recognise the need to use the toilet, they should be regularly toileted</td>
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<td>Clothes can be adjusted to make it easier to access the toilet</td>
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<td>Clothes can be adjusted to make it easier to access the toilet</td>
<td>All patients should have a periodic review of their initial assessment to monitor the effectiveness of their treatment/management plan and to ensure there is adequate clinical improvement (DH, 2000)</td>
</tr>
</tbody>
</table>

With an increasingly ageing population, a growing incidence of bladder and bowel problems — not to mention the variety of types of patients affected including people with dementia and neurological problems such as spinal cord injury, stroke and multiple sclerosis — means that continence services need to be given a greater priority.

Aiming to achieve continence targets will provide primary care and community teams with a mechanism for constant improvement when caring for these patient groups. According to Maben and Griffith (2008), good quality nursing means providing ‘a good experience for patients’ through one of six core nursing elements:

- A holistic approach to physical, mental and emotional needs, patient-centred and continuous care
- Efficiency and effectiveness combined with humanity and compassion
- Professional, high quality evidence-based practice
- Safe, effective and prompt nursing interventions
- Patient empowerment, support and advocacy
- Seamless care through effective teamwork with other professions.

Whatever targets are used, quality improvement, clinical effectiveness and patient safety should be paramount.

du Moulin et al (2005) highlighted that nursing treatment of incontinence in community patients — involving a holistic approach to their physical, mental and emotional needs through patient-centred care — is beneficial in terms of clinical outcomes.

Moore (2003) speculated that the greater amount of time nurses are able to spend with patients might be the main benefit here (nurses’ consultation.
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times ranges from 15 minutes to one hour in various clinical sectors).

However, while there are established services for patients with incontinence in the UK, the provision of treatment remains inconsistent with many clinicians failing to diagnose the underlying causes of incontinence, not recognising the symptoms or failing to recommend treatment (Milne, 2000). In addition, constraints upon consultation time, delayed referrals and conflicting continence advice across healthcare services have also been reported (Davis and Kumar, 2003).

In 2011, the APPG indicated that effective community-based continence services can save valuable NHS resources while restoring dignity and improving quality of life. However, for a service to be fit for purpose, it requires knowledge, skills and the right attitude to cope with a wide variety of complex long-term conditions. Nurses have to come to a decision how best to deal with these increasingly common issues and there is a choice to be made between simply offering pads or instigating ongoing evidence-based care.

Eustice (2015) acknowledged that making a case for the continence needs of future generations requires serious investment and involves more focused education and training for all community practitioners. Similarly, Orell et al (2013) established that improving attitudes towards continence and older people, together with more prompt and efficient patient referral pathways, strengthening inter-service collaborations, investing in service capacity, and a higher profile given to urinary continence within medical and nurse training could improve the standards of care for older people with urinary incontinence.

Similarly, continence care must be included in preregistration nursing degrees, with programmed placements in specialist continence services and minimum standards for community nurse education. Currently, clinicians have to search for local bladder and bowel study days provided by specialist nurses.

Self-referral to continence services can improve access to care, while community nurses should seek to develop working relationships with community bladder and bowel specialists so that they can access the latest advice and appropriate products. Further to this, community nurses need to consider using continence integration models to review referral and care pathways — each trust should have its own continence integrated working group, dedicated to providing specialist continence nurses who work in collaboration with specialist clinics such as colorectal, urology or urology/nephrology for further management when all conservative measures have failed or when patients request further management (DH, 2000).

It should also be acknowledged that better care provision is more cost-effective, while poor care involves rectifying mistakes and correcting poor treatment and is more expensive in the long term. It is important to make the case that specialist nurses should be available to support their community colleagues with advice on complex cases (Eustice, 2015).

CONCLUSION

Many continence problems can be cured and certainly many patients’ issues could be better managed. People have the right to be heard, receive the right treatment at the right time and live the best achievable quality of life possible. Managing incontinence is a complex process but lifestyle changes and conservative management strategies can greatly improve the quality of life for community patients. As healthcare professionals, community nurses need to assess the multifactorial reasons why urinary incontinence may be a problem and work with patients to minimise or eliminate any reversible causes.

Creative partnerships involving different professionals within health organisations (community nurses; GPs; continence nurse specialists; physiotherapists, etc), alongside delivery plans that include self-management support, education and engagement with community stakeholders, will improve continence care in patients living in the community.

This kind of professional integration will work when there are committed networks of healthcare professionals working towards the common goal of successfully supporting older adults to manage their chronic conditions.

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